**DRUG MEDI-CAL**
**INFORMATION NETWORK PROJECT (INP)**
**REJECTED/RESUBMISSION FORM**

**Type of Submission (Check one):**

Ė **REJECTED CLAIM =** Bad records that would have caused the entire claim to be rejected returned to the county for correction. The INP (e-mail) notice of bad records from the original submission must accompany this form to verify the type and necessity of this claim.

Ė **RESUBMISSION =** Claims that have been previously submitted and denied. Providers have up to 6 months from the date of the denial to resubmit claims that were denied. A copy of denied claims report must accompany this form. (Title 22 CCR 51008.(d))

**Date: _____** **County: _____**

**Claim Mo/Yr: _____** **Program Code: _____**

**Units of Service: _____** **Total Amount Claimed: _____**

**Total Records:_____**

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